"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Indiana Division of Aging
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

E. Mitchell Roob, Jr, Secretary

Thank you for your interest in providing services for the Medicaid Home and Community-Based Services Waivers. Enclosed are the following documents:

- Assisted Living Service Information Sheet and Rates
- Assisted Living Level of Service Assessment/Evaluations List
- Assisted Living Final Rule (460 IAC 8)
- Assisted Living Survey Tool
- Disclosure for Housing with Services Establishments Form
- Nursing Facility Level of Care Waiver Provider Information website sheet
- Provider application for the Nursing Facility Level of Care Waiver (s)
- Provider Agreement (Schedule A)
- W-9 Tax Identification Number and Certification
- County Survey with a list of the 16 Area Agencies on Aging

Please complete the application, provider agreement, W-9, and county survey with dates and signatures and return them along with the specific documents and other information required for the service (s) for which you wish to be approved.

Please contact Ava Y. Taylor, Program Manager at (317) 232.7149 or Linda Wolcott, Certification Specialist at (317) 234.0373 with any questions you may have.

To request additional waiver documents, contact the Waiver Secretary at (317) 232.7122.

The completed application and attachments should be returned to:

Linda Wolcott, Waiver Operations
MS 21 Division of Aging
402 West Washington Street, Room W454
P.O. Box 7083
Indianapolis, Indiana 46207-7083

Enclosures

Assisted Living

Provider Packet & Application for the Aged and Disabled Waiver
FSSA Waiver Services
Division of Aging

Assisted Living Service

Individuals who are at least 18 years old and meet intermediate Nursing Facility Level of Care and are Medicaid eligible may be eligible to receive the Assisted Living Service under the Assisted Living (AL) or Aged and Disabled (A&D) Waiver. If a client chooses to utilize the Assisted Living Service, the only other service they are allowed to have is case management. The case management service must be provided by a person not employed by the residential care facility.

Clients requiring intermittent skilled nursing services (PT, OT, etc.) should seek Medicaid Prior Authorization under the Medicaid State Plan for such services.

The Assisted Living Service is a bundle of services provided by the residential care facility in a home-like environment. These services include:

Attendant care;
Chores;
Companion services;
Homemaker;
Medication oversight (to the extent permitted under State law);
Personal care and services; and
Therapeutic social and recreational programming

- The Assisted Living Service can only be provided by a residential care facility that is licensed by the Indiana State Department of Health under the guidelines of 410 IAC 16.2 and is Medicaid Waiver certified.
- The Assisted Living Service requires 24 hour on-site response staff to meet scheduled or unscheduled needs in a way that promotes maximum dignity and independence and to provide supervision, safety, and security.
- The Residential Care Facility must provide the above mentioned services either by their own staff or by a licensed contracted entity without an additional fee to the client for these services.
- Personalized care must be furnished to clients who reside in their own living units, which may include dually occupied units only if both parties request it in writing and agree to the arrangement.
- The client's unit must include a kitchenette, living area, bedroom area, and toilet facilities. (See 460 IAC 8 for specifics)
- A person receiving the Assisted Living Service is considered to be living in a community setting, not an institutional setting.
- Documented records of services and medications that are to be provided, indicating by whom, and at what frequency, is to be maintained for each client by the facility.

Service Units/Billing

- The Assisted Living Service is a per diem rate.
- There are three per diem rates for this service based on the needs of the client.
- The client must first meet intermediate nursing facility level of care.
- The Assisted Living Service needs of the clients are determined by completing the *Level of Service Assessment Evaluation Tool*. Completion of this tool is mandatory. Usually the

Case manager, the client, the client's family, and someone from the facility will participate in the evaluation. The level of needs for the client will be determined by the points from this assessment.

- The *Level of Service Assessment Evaluation Tool* us to be completed a minimum of once a year.
- A re-assessment can be done at any time, if deemed appropriate.
- A client who has a higher point value than 75 is not eligible for the Assisted Living Service.

Level	*Assessment Points*	*Per Diem Rates as of 7/1/07*
1	*36*	*$62.74*
2	*37-60*	*$71.85*
3	*61-75*	*$80.93*

- The Assisted Living service per diem does not cover room and board expenses.
- The per diem pays for the Medicaid eligible waiver services provided by the facility.
- The Facility can charge the client up to the current amount of the SSI maximum ($623.00) for room and board.
- The client is entitled to retain his or her full Personal Needs Allowance (PNA is $52.00) out of his or her personal income, even if it means the facility does not receive the entire amount of the SSI maximum.
- A client may have a Medicaid spend-down in his or her budget.
- The Assisted Living Medicaid per diem can be used to satisfy the monthly spend-down.

Assisted Living Medicaid Waiver Rates effective 7-1-07

Assisted Living	Unit		Cap Rate	Code & Modifiers	Prior Authorization & Audit Criteria
Assisted Living - Level 1	1	Day	$ 62.74		The rate is $62.74/day. Max 1 unit/day
Assisted Living - Level 2	1	Day	$ 71.85		The rate is $71.85/day. Max 1 unit/day
Assisted Living - Level 3	1	Day	$ 80.93		The rate is $80.93/day. Max 1 unit/day

Level of Service Assessment/Evaluation
For
Assisted Living

(Provided for information purposes only)

Answers to questions are worth specific points.
The total points determine the level of service and corresponding per diem.

Level 1: 1-36 points
Level 2: 36-60 points
Level 3: 61-75 points

Level of Service Assessment/Evaluation - Full List of Items
Assisted Living

Client: _____ Date: _____

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RECEPTIVE COMMUNICATION	Points
1. Understands information conveyed without difficulty.	0
2. Understands information conveyed. May miss some part or intent of the message.	1
3. Rarely/never understands information conveyed. May or may not hear. May or may not understand the language.	3

EXPRESSIVE COMMUNICATION	Points
1. Communicates information and is understood.	0
2. Ability to express self is limited to making concrete requests regarding basic needs.	1
3. Does not communicate or convey needs. May or may not hear.	3

ORIENTATION	Points
1. Oriented to person, place and time OR Sufficiently oriented to function independently if in familiar surroundings.	0
2. Disoriented to the point of no longer able to function independently 3 or more days a week or part of every day for a 7-day period.	2
3. Always disoriented. People who perform a repetitive behavior.	3

ADAPTATION TO CHANGE	Points
1. Actively adapts and makes plans, handles crisis well, is confident, adjusts to major changes.	0
- OR -	
2. Needs reassurance only at time of major decisions.	
3. Needs reassurance 3 or more days in a 7-day period. May refuse to make decisions. May be negative or hostile. May be passive or withdrawn.	2
4. Needs daily support and reassurance while change is being discussed, when decisions are being made and while changes are being implemented. May be afraid or insecure.	6
5. Constantly confused or disoriented. May or may not be comatose.	4

JUDGMENT	Points
1. Decisions are made in an organized manner, daily routine and decisions are consistent, reasonable, and organized reflecting lifestyle, culture and values.	0
2. Organized daily routine and makes safe decisions in familiar situations. Experiences difficulty in decision-making when faced with new tasks or situations.	3
3. Decisions are poor, requiring cueing and supervision in planning, organizing and correcting daily routines.	4
4. Decision-making was severely impaired, rarely or never makes decisions.	6

MEMORY	Points
1. No difficulty remembering and using information. Does not require directions or reminding from others.	0
- OR -	
2. Requires cueing less than 3 times in a 7-day period.	
3. Has difficulty remembering and using information. Requires at least daily cueing from others. Cannot read written direction.	3
4. Cannot remember or use information. Requires continual verbal reminding.	5

Client: _____ Date: _____

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AWARENESS OF OWN NEEDS	Points
1. Understands those needs that must be met for self-maintenance.	0
2. Has difficulty understanding those needs, which must be met, but will cooperate when given direction or explanation.	1
3. Does not understand those needs that must be met for maintenance AND will not consistently cooperate even though given direction or explanation.	4

BEHAVIOR (Demands on Others)	Points
1. Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions.	0
- OR -	
2. Attitudes, habits and emotional states limit the individual's type of living arrangement and companions.	
3. Attitudes, disturbances and emotional states create less than daily difficulties, which are modifiable to tolerable levels given training and patience on the part of the caregiver. May be actively abusing substances.	5
4. Attitudes, disturbances and emotional states create daily difficulties, which are extremely difficult to modify to tolerable levels and can only be modified in a special setting and/or with a special plan.	10

WANDERING	Points
1. Does not wander. May be chair or bed bound. Defined as: Moving with no rational purpose, seemingly oblivious to needs or safety. THIS IS NOT PACING	0
2. Wanders within the facility or residence. May wander outside, health and safety may be jeopardized. Is not combative about redirection. Defined as: Moving with no rational purpose, seemingly oblivious to needs or safety. THIS IS NOT PACING	3
3. Wanders within the facility or residence. May wander outside less than 3 times in a 7-day period. Wanders into other residents rooms and may take the belongings of others. Defined as: Moving with no rational purpose, seemingly oblivious to needs or safety. THIS IS NOT PACING	5
4. Wanders outside 3 or more times in a 7-day period and leaves grounds. Has a consistent history of leaving grounds, getting lost or being combative about returning. Defined as: Moving with no rational purpose, seemingly oblivious to needs or safety. THIS IS NOT PACING	7

NIGHT NEEDS	Points
1. Does not require care from another person during night.	0
2. Requires care and supervision more than 3 times in a 7-day period during the night. Sleeps at least five hours during an eight-hour period.	5
3. Requires care 7 nights a week as well as supervision. Sleeps less than five hours during an eight-hour period.	10

Client: _____ Date: _____

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FEEDING	Points
1. Can feed self, chew and swallow foods without difficulty, or can feed self by stomach tube or catheter.	0
2. Can feed self, chew and swallow foods, but needs cueing to maintain adequate intake of liquids and solids; or may need food cut up. - OR - 3. Can feed self only if food is brought to them or on a liquid diet.	2
4. Can feed self but needs standby assistance for gagging, choking or swallowing difficulty, or assistance with feeding appliances. - OR - 5. Must be fed all food by mouth or constant cueing during EACH meal.	4
6. Must be fed by another person and during each meal gags or chokes due to difficulty swallowing.	8

TRANSFERRING	Points
1. The client is able to get into and out of bed, get into and out of a chair, get into and out of the tub or roll over in bed without assistance from anyone.	0
2. Transfers and changes position consistently, but needs direct assistance less than 3 times in a 7-day period. Episodes when client can't get up from sitting or reclining position without assistance. Client needs cueing for safety.	2
3. Can assist with own transfers and position changes, but needs direct assistance 3 or more times in a 7-day period. The client needs cueing most of the time. This includes person who will attempt transfers or position changes unsafely.	5
4. Someone else must do transfers all of the time. Client is not able to bear weight, does not have enough strength to assist with a transfer or position change and is dependent on someone else all of the time or not cooperative with transfers.	15
5. Transfers and position changes require two or more people. Dependent on two or more people for all position changes and transfers OR one person and a Hoyer lift.	20

DRESS/UNDRESS	Points
1. Can dress and undress without assistance or supervision.	0
2. Can dress and undress, but needs cued to do so 3 or more times in a 7-day period.	1
3. Needs direct assistance from another person for parts of dressing and undressing, such as pulling up pants / manipulating fasteners, 3 or more times in a 7-day period.	2
4. Dependent on others to provide all dressing and undressing.	4

BATHING	Points
1. Can bathe without reminders and without any assistance or supervision. - OR - 2. Can bathe without assistance or supervision but must be reminded 1 time in a 7-day period.	0
3. Is highly involved in the activity but requires assistance with minimal parts of bathing, i.e., wash back, feet, rinse hair, etc. Includes person who cannot get into the bathtub/shower and may require some other standby assistance and/or bathing equipment.	2
4. Performs part of the activity but requires substantial assistance with most parts of bathing function, i.e., get water, lather cloth, wash and rinse body or hair.	4
5. Dependent on others to provide complete bath, including shampoo and constant supervision for safety.	6

Client: _____ Date: _____

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PERSONAL HYGIENE	Points
1. Can manage personal hygiene regularly without reminders, assistance or supervision.	0
2. Can manage personal hygiene but must be reminded 3 or more times in a 7-day period.	1
3. Always requires assistance with personal hygiene.	2
4. Dependent on others to provide all personal hygiene.	4

TOILETING	Points
1. Can toilet self without physical assistance or supervision. May need grab bars/raised toilet seat or can manage own closed drainage system if he/she has a catheter, sheath or uses protective aids.	0
(Address physical and cognitive abilities; address the amount of assistance needed.)	
2. Needs standby assistance for safety or encouragement. May need physical assistance with parts of the task, such as clothing adjustment, washing hands, etc. less than 3 times in a 7-day period.	2
(Address physical and cognitive abilities; address the amount of assistance needed.)	
3. Needs physical assistance with parts of the task, such as wiping, cleansing, clothing adjustment, and etc. 3 or more times in a 7-day period. May need a protective garment. May or may not be aware of need. May need additional help because of excess weight.	4
(Address physical and cognitive abilities; address the amount of assistance needed.)	
4. Cannot get to the toilet unassisted or needs someone else to manage care of closed drainage system if they have a catheter or sheath. May or may not be aware of need; includes clients on toileting schedules.	6
(Address physical and cognitive abilities)	
5. Physically unable to be toileted. Requires continual observation and total cleansing. May require protective garments or padding or linen changes. May or may not be aware of need.	8
(If client were a 5 in toileting, client would be AT LEAST a 5 in bowel and bladder).	

BLADDER CONTROL (Incontinency)	Points
1. Manages own care. May be continent, incontinent, dribble, wear external sheath, an indwelling catheter or a urinary ostomy.	0
2. Requires assistance less than weekly with incontinency, or needs someone else less than weekly to manage occasional sheath change, catheter care, or urinary ostomy care.	1
3. Requires assistance less than daily to manage catheter, sheath care, urinary ostomy or incontinency.	2
4. Needs assistance daily to manage catheter or sheath changes, urinary ostomy, incontinency or dribbling.	4
5. Totally incontinent day or night, dependent on others for care.	7
6. Totally incontinent day and night, dependent on others for care AND urinates in inappropriate places or refuses to use incontinency supplies.	9

BOWEL CONTROL (Incontinency)	Points
1. Manages own care. May be continent, incontinent or has an ostomy.	0
2. Requires assistance less than weekly with incontinency or ostomy care.	2

Client: _____ Date: _____

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BOWEL CONTROL (Incontinency)	Points
3. Requires assistance less than daily to manage incontinency, ostomy care or suppository insertion.	3
4. Needs assistance daily to manage incontinency, ostomy care or suppository insertion.	4
5. Totally incontinent day or night, dependent on others for care.	7
6. Totally incontinent day or night, dependent on others for care AND plays with feces.	9

MOBILITY	Points
1. Totally independent. Can get to grocery store, both functionally and cognitively.	0
2. Can get around inside without assistance but needs assistance of another person outside. Endurance limited to immediate vicinity of facility. Requires constant presence of staff for safety outside.	2
3. Needs direct assistance of another person inside 3 or more times in a 7-day period. Needs assistance of another person outside. Risk of falling inside and outside. Poor gait inside and outside. May have difficulty getting from room to room based on endurance and stability. Arm strength or cognitive ability to use mechanical aids is limited.	3
4. Can only get around with regular assistance of another person both inside and outside. Not safe to ambulate alone. Needs constant cueing or standby assistance inside and outside to address safety. Does not have required strength or endurance to use mechanical aids.	6
5. Cannot get around even with regular assistance. Bed bound, comatose person requiring range of motion exercises daily.	5

MEDICATION PROCEDURES	Points
No Medication Procedures.	0
Caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect. Round the clock need.	10
Assistance in administration of prescribed inhalation therapy (nebulizers and metered dose inhalers). At least two times per day. (BID, TID, QID, Round the clock need).	10
Insulin injections administered per caregiver and/or fingerstick glucose monitoring. At least one time per day. (BID, TID, QID, Round the clock need).	10

TREATMENT PROCEDURES	Points
No Treatment Procedures.	0
Direct assistance with care of cast, splint and brace.	10
Direct assistance evaluating urinary output and fluid balance because of medical condition.	10
Direct assistance of urinary catheters requiring more than monthly changes and/or weekly irrigation.	10
Direct assistance with enemas/suppositories 3 or more times in a 7-day period.	10
Impaction removal 3 or more times in a 30-day period.	10
Direct assistance in care of ileostomy or colostomy.	10
Restorative nursing for daily passive range of motion.	10

Assisted Living

Client: _____ Date: _____

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TREATMENT PROCEDURES	Points
Daily care of non-infected lesions and/or wounds.	10
Behavior management program when based on documented plan.	10
Direct assistance with oxygen administration.	10
Daily direct assistance in care and maintenance of prosthetic devices.	10

Assisted Living Medicaid Waiver

Final Rule 460 IAC 8

Division of Aging

11/04

Document: Final Rule, **Register Page Number:** 27 IR 2489
Source: May 1, 2004, Indiana Register, Volume 27, Number 8
Disclaimer: This document was created from the files used to produce the official CD-ROM Indiana Register.

TITLE 460 DIVISION OF DISABILITY, AGING, AND REHABILITATIVE SERVICES

LSA Document #03-99(F)

DIGEST

Adds 460 IAC 8 concerning providers of assisted living services under the Medicaid waiver authorized by Public Law 100-2000. Effective 30 days after filing with the secretary of state.

460 IAC 8

SECTION 1. 460 IAC 8 IS ADDED TO READ AS FOLLOWS:

ARTICLE 8. ASSISTED LIVING MEDICAID WAIVER SERVICES

Rule 1. Assisted Living Medicaid Waiver Services

460 IAC 8-1-1 Applicability
Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-15; IC 16-28

Sec. 1. This rule applies to the provision of assisted living Medicaid waiver services in residential care facilities licensed under IC 16-28 and 410 IAC 16.2-5. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 8-1-1; filed Apr 8, 2004, 3:15 p.m.: 27 IR 2489)*

460 IAC 8-1-2 Definitions
Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-8-6-1; IC 12-9-1-1; IC 12-10-1-1; IC 12-10-1-4; IC 12-10-13-4.5; IC 12-15; IC 16-28; IC 16-36-1-5

Sec. 2. The following definitions apply throughout this rule:
(1) "Activities of daily living" means those personal functional activities required by a recipient for continued well-being including:
(A) mobility;
(B) dressing;
(C) bathing;
(D) eating;
(E) toileting; and
(F) transferring.
(2) "Aging in place" means being in a care environment that will provide the recipient with a range of care options as the needs of the recipient change. Aging in place does not preclude assisting a recipient in relocating to a new care environment if necessary.
(3) "Applicant" means a natural person or entity that applies to provide assisted living Medicaid waiver services.
(4) "Area agency on aging" means the agency designated by the BAIHS services in each planning and service area under IC 12-10-1-4(18).
(5) "Assessed impairment level" means the level of service needed by a recipient as determined using the level of service assessment form.
(6) "Assisted living Medicaid waiver services" means the array of services provided to a recipient residing

in a facility, including any or all of the following:

(A) Personal care services.

(B) Homemaker services.

(C) Chore services.

(D) Attendant care services.

(E) Companion services.

(F) Medication oversight (to the extent permitted under state law). and

(G) Therapeutic social and recreational programming.

(7) "Assisted living Medicaid waiver services provider" means an entity approved to provided *[sic., provide]* **assisted living Medicaid waiver services.**

(8) "Attendant care" means hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual.

(9) "BAIHS" means the bureau of aging and in-home services as created under IC 12-10-1-1.

(10) "Case manager" means the individual or agency enrolled by the office of Medicaid policy and planning chosen by the recipient to provide case management services.

(11) "Choice" means a recipient has viable options that enable him or her to exercise greater control over his or her life. Choice is supported by the provision of sufficient private and common space within the facility to provide opportunities for recipients to select where and how to spend time and receive personal assistance.

(12) "Chore services" means services needed to maintain the recipient's residential unit in a clean, sanitary, and safe environment.

(13) "Companion services" means nonmedical care, supervision, and socialization services. It does not include assisting or supervising the recipient with meal preparation, laundry, or shopping.

(14) "Complaint" means an allegation that an assisted living Medicaid waiver services provider has violated this article or a dissatisfaction relating to the condition of the facility or the recipient(s).

(15) "Dignity" means providing support in such a way as to validate the self-worth of the recipient. Dignity is supported by designing a structure that allows personal assistance to be provided in privacy and delivering services in a manner that shows courtesy and respect.

(16) "Division" means the division of disability, aging, and rehabilitative services created under IC 12-9-1-1.

(17) "Facility" a means facility licensed under IC 16-28 and 410 IAC 16.2-5.

(18) "Homelike" means an environment that has the qualities of a home, including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences, which promotes the dignity, security, and comfort of recipients through the provision of personalized care and services to encourage independence, choice, and decision making by the recipients. A homelike environment also provides recipients with an opportunity for self-expression and encourages interaction with the community, family, and friends.

(19) "Homemaker services" means services consisting of general household activities, including meal preparation and routine household care.

(20) "Independence" means being free from the control of others and being able to assert one's own will, personality, and preferences within the parameters of the house rules or residency agreement.

(21) "Interdisciplinary team" means a group of individuals, which must include the recipient, and which may be composed of, but is not limited to:

(A) the recipient's family and/or legal representative;

(B) the recipient's case manager;

(C) a licensed nurse; and

(D) the provider(s) of service;

who work together to develop the recipient's individual plan of care.

(22) "Legal representative" means a person who is:

(A) a guardian;

(B) a health care representative;

(C) an attorney in fact; or

(D) a person authorized by IC 16-36-1-5 to give health care consent.

(23) "Level of service" means the specific level of service that an assisted living Medicaid waiver services

provider is authorized to provide to a recipient in accordance with the recipient's plan of care and that is based on the assessed impairment level of the recipient.
(24) "Medication oversight services" means personnel operating within the scope of applicable licenses and/or certifications providing reminders or cues to recipients to take medication, open preset medication containers, and handle and/or dispense medication.
(25) "Office of Medicaid policy and planning" means the office of Medicaid policy and planning created by IC 12-8-6-1.
(26) "Ombudsman" means a representative of the office of the state long term care ombudsman as provided in IC 12-10-13-4.5.
(27) "Personal care services" means assistance with:
(A) eating;
(B) bathing;
(C) dressing;
(D) personal hygiene; and
(E) activities of daily living.
(28) "Plan of care" means the written plan developed by the interdisciplinary team, on which the recipient's case manager documents the proposed Medicaid waiver services, the Medicaid state plan services, as well as other medical services and social services and informal community supports that are needed by the recipient to ensure the health and welfare of the recipient.
(29) "Provider" means an entity approved under this article to provider *[sic., provide]* **assisted living Medicaid waiver services.**
(30) "Recipient" means an individual who is receiving assisted living Medicaid waiver services.
(31) "Room and board" means the provision of:
(A) meals;
(B) a place to sleep;
(C) laundry; and
(D) housekeeping.
(32) "Service plan" means a written plan for services to be provided by the provider, developed by the provider, the recipient, and others, if appropriate, on behalf of the recipient, consistent with the services needed to ensure the health and welfare of the recipient. It is a detailed description of the capabilities, needs, choices, measurable goals, and if applicable the measurable goals and managed risk issues, and documents the specific duties to be performed for the recipient, including who will perform the task, when, and the frequency of each task based on the individual's assessed needs and preferences.
(33) "Services" means activities which help a recipient develop skills to increase or maintain level of functioning or which assist the recipient in performing personal care or activities of daily living or individual social activities.
(34) "Supportive services" means services which substitute for the:
(A) absence;
(B) loss;
(C) diminution; or
(D) impairment;
of a physical or cognitive function.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 8-1-2; filed Apr 8, 2004, 3:15 p.m.: 27 IR 2489)

460 IAC 8-1-3 Provider approval
Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-15; IC 12-15; IC 16-28

Sec. 3. In order to be approved by the division to provide assisted living Medicaid waiver services, an applicant shall do the following:
(1) Complete an application form prescribed by the division.
(2) Submit evidence that the applicant:
(A) Has a license required by IC 16-28 and 410 IAC 16.2-5 for each facility at which assisted living

Medicaid waiver services will be provided.

(B) Has registered each facility at which assisted living services will be provided as a housing with services establishment under IC 12-10-15.

(3) Indicate what level of services the applicant will provide.

(4) Submit a written and signed statement that the applicant will comply with the provisions of this article.

(5) Submit a written and signed statement that assisted living Medicaid waiver services will not be provided at a facility that is not licensed pursuant to IC 16-28 and 410 IAC 16.2-5.

(6) Submit a written and signed statement that assisted living Medicaid waiver services will not be provided at a facility that is not registered as a housing with services establishment under IC 12-10-15.

(7) Submit a written and signed statement that the applicant will provide services to a recipient as set out in the recipient's plan of care.

(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 8-1-3; filed Apr 8, 2004, 3:15 p.m.: 27 IR 2491)

460 IAC 8-1-4 Decision on approval; administrative review; provider agreement

Authority: IC 12-8-8-4; IC 12-9-2-3

Affected: IC 4-21.5; IC 12-10-15; IC 12-15; IC 16-28

Sec. 4. (a) The division shall determine whether an applicant meets the requirements under this article.

(b) The division shall notify an applicant in writing of the division's determination within sixty (60) days of submission of a completed application.

(c) If an applicant is adversely affected or aggrieved by the division's determination, the applicant may request administrative review of the determination. Such request shall be made in writing and filed with the director of the division within fifteen (15) days after the applicant receives written notice of the division's determination. Administrative review shall be conducted pursuant to IC 4-21.5.

(d) Once an applicant has been approved by the division to provide assisted living Medicaid waiver services, an applicant cannot provide assisted living Medicaid waiver services until the applicant has completed and submitted a Medicaid waiver assisted living provider agreement.

(e) No person or entity shall represent themselves as operating as an assisted living Medicaid waiver provider or accept placement of a recipient without first being approved to provide assisted living Medicaid waiver services. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 8-1-4; filed Apr 8, 2004, 3:15 p.m.: 27 IR 2491)*

460 IAC 8-1-5 Facility requirements

Authority: IC 12-8-8-4; IC 12-9-2-3

Affected: IC 12-10-15-7; IC 12-15; IC 16-28

Sec. 5. (a) Each facility at which assisted living Medicaid waiver services are provided shall meet the following requirements:

(1) Maintain a current residential care facility license as required by IC 16-28 and 410 IAC 16.2-5.

(2) Comply with the requirements of IC 12-10-15.

(3) Provide assisted living Medicaid waiver service recipients with individual residential living units that include the following:

(A) A bedroom.

(B) A private bath.

(C) A substantial living area. and

(D) A kitchenette that contains:

(i) a refrigerator;

(ii) a food preparation area; and

(iii) a microwave or stovetop for hot food preparation.

(b) If a facility was in operation prior to July 1, 2001, and was in compliance with the requirements of IC 12-10-15-7 on June 30, 2001, individual living units provided to recipients shall have a minimum of one hundred sixty (160) square feet of livable floor space including closets and counters, but excluding space occupied by the bathroom.

(c) If a facility was in operation prior to the effective date of this rule and was licensed under 410 IAC 16.2-5, individual living units provided to recipients shall contain the following:

(1) A substantial living area of at least one hundred sixty (160) square feet of livable floor space, including closets and counter space, but excluding space occupied by the bathroom.

(2) A sleeping area, not necessarily designated as a separate bedroom from the living area.

(3) A semiprivate bath or shower.

(4) A kitchenette that contains:

(A) a refrigerator;

(B) a food preparation area; and

(C) a microwave. and

(5) Access to a stovetop/oven for hot food preparation in the common area.

(d) All other facilities shall provide recipients with individual living units meeting the following additional requirements:

(1) Contain a minimum of two hundred twenty (220) square feet of livable space including closets and counters, but excluding space occupied by the bathroom.

(2) Contain a bath that is wheelchair accessible. Fifty percent (50%) of the units available to recipients shall have a roll-in shower. and

(3) Contain individual thermostats.

(e) Residential units provided to recipients must be single units unless the recipient chooses to live in dual-occupied unit and the recipient and the other occupant consent to the arrangement.

(f) Residential units provided to recipients shall be able to be locked at the discretion of the recipient, unless a physician or a mental health professional certifies in writing that the recipient is cognitively impaired so as to be a danger to self or others if given the opportunity to lock the door. This subsection does not apply if this requirement conflicts with applicable fire codes. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 8-1-5; filed Apr 8, 2004, 3:15 p.m.: 27 IR 2491)*

460 IAC 8-1-6 Assisted living Medicaid waiver services

Authority: IC 12-8-8-4; IC 12-9-2-3

Affected: IC 12-15; IC 16-28-13-1

Sec. 6. (a) The provider shall provide the following assisted living Medicaid waiver services:

(1) Personal care services.

(2) Homemaker services.

(3) Chore services.

(4) Attendant care services, including supportive services.

(5) Companion services.

(6) Medication oversight services, as permitted by state law. and

(7) Therapeutic, social, and recreational programming.

(b) Assisted living Medicaid waiver services shall be provided to a recipient as outlined in a recipient's plan of care, as developed by the recipient's case manager and interdisciplinary team, as follows:

(1) The provider shall provide the intensity and level of services as outlined in the recipient's plan of care. The intensity and level of services shall range from level 1 for recipients who are the least impaired and require the least intense level of services to level 3 for the most severely impaired recipients who require the most intense level of services.

(2) Should a recipient require more intense assisted living Medicaid waiver services (a higher level of

services) than the provider is approved to provide, or require services more intense than level 3, the provider shall assist the recipient in transferring to a more appropriate setting and shall observe all discharge requirements of 410 IAC 16.2-5.

(c) The initial plan of care must be approved by the office of Medicaid policy and planning prior to the initiation of assisted living Medicaid waiver services. It must be updated at least every ninety (90) days and annually or when the recipient experiences a significant change per 410 IAC 16.2-1.1-70.

(d) Provider staff shall provide information to the recipient's interdisciplinary team, as requested by the recipient's interdisciplinary team. If requested by a recipient and/or recipient's case manager, appropriate provider staff shall serve on a recipient's interdisciplinary team.

(e) All direct care shall be provided by personnel specified in IC 16-28-13-1.

(f) As appropriate, services shall be provided to recipients in their own living units.

(g) The physical environment and the delivery of assisted living Medicaid waiver services shall be designed to enhance autonomy in ways which reflect personal and social values of dignity, privacy, independence, individuality, choice, and decision making of recipients. The provider shall provide services in a manner that:

(1) makes the services available in a homelike environment for recipients with a range of needs and preferences;

(2) facilitates aging in place by providing flexible services in an environment that accommodates and supports the recipient's individuality; and

(3) supports negotiated risk, which includes the recipient's right to take responsibility for the risks associated with decision making.

(h) If requested by a recipient, the provider will assist a recipient and a recipient's case manager in obtaining, arranging, and coordinating services outlined in a recipient's plan of care that are not assisted living Medicaid waiver services.

(i) Should other entities furnish care directly, or under arrangement with the provider, that care shall supplement the care provided by the provider but may not supplant it. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 8-1-6; filed Apr 8, 2004, 3:15 p.m.: 27 IR 2492)*

460 IAC 8-1-7 Levels of service; level of service assessment/evaluation tool; provider enrollment

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-15

Sec. 7. (a) Assisted living Medicaid waiver services will be provided and paid according to three (3) levels of service, with level one (1) being the least impaired and level three (3) the most impaired/dependent. No assisted living Medicaid waiver services may be provided that meet the skilled level of care as defined in 405 IAC 1-3-1.

(b) The impairment level assessment tool for assisted living Medicaid waiver services will be based on the point system definitions designated on the level of service assessment form and will be documented on forms prescribed by the division. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 8-1-7; filed Apr 8, 2004, 3:15 p.m.: 27 IR 2493)*

460 IAC 8-1-8 General service standards

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-15

Sec. 8. (a) A provider shall provide assisted living Medicaid waiver services only to persons approved by

the office of Medicaid policy and planning to receive assisted living Medicaid waiver services.

(b) A provider shall:
(1) promote the ability of recipients to have control over their time, space, and lifestyle to the extent that the health, safety, and well-being of other recipients is not disturbed;
(2) promote the recipient's right to exercise decision making and self-determination to the fullest extent possible;
(3) provide services for recipients in a manner and in an environment that encourages maintenance or enhancement of each recipient's quality of life and promotes the recipient's:
(A) privacy;
(B) dignity;
(C) choice;
(D) independence;
(E) individuality; and
(F) decision making ability; and
(4) provide a safe, clean, and comfortable homelike environment allowing recipients to use their personal belongings to the extent possible.

(c) The provider shall complete a service plan within thirty (30) days of move-in or the recipient's receipt of assisted living Medicaid waiver services.

(d) The provider shall ensure the service plan:
(1) includes recognition of the recipient's capabilities and choices and defines the division of responsibility in the implementation of services;
(2) addresses, at a minimum, the following elements:
(A) assessed health care needs;
(B) social needs and preferences;
(C) personal care tasks; and
(D) limited nursing and medication services, if applicable, including frequency of service and level of assistance;
(3) is signed and approved by:
(A) the recipient;
(B) the provider;
(C) the licensed nurse;
(D) the case manager; and
(4) includes the date the plan was approved.

(e) The service plan shall support the principles of dignity, privacy, and choice in decision making, individuality, and independence.

(f) The provider shall provide the recipient, case manager, and area agency on aging with a copy of the service plan and place a copy in the recipient's record.

(g) The provider shall update the plan when there are changes in the services the recipient needs and wants to receive. At a minimum, the provider shall review the service plan every ninety (90) days for assisted living recipients. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 8-1-8; filed Apr 8, 2004, 3:15 p.m.: 27 IR 2493)*

460 IAC 8-1-9 Negotiated risk plan appropriate to level of service
Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-15

Sec. 9. (a) If deemed appropriate and determined to be necessary by a recipient's interdisciplinary team, the provider shall establish a negotiated risk plan with a recipient.

(b) The negotiated risk plan shall address unusual situations in which a recipient's assertion of a right, preference, or behavior exposes the recipient or someone else to a real and substantial risk of injury.

(c) The negotiated risk plan shall identify and accommodate a recipient's need in a way that is acceptable to both the provider and the recipient.

(d) A negotiated risk plan shall include:
(1) an explanation of the cause(s) of concern;
(2) the possible negative consequences to the recipient and/or others;
(3) a description of the recipient's preferences;
(4) possible alternatives or interventions to minimize the potential risks associated with the recipient's preference/action;
(5) a description of the assisted living Medicaid waiver services the provider will provide to accommodate the recipient's choice or minimize the potential risk and services others ***[sic., other]*** **entities will provide to accommodate the recipient's choice or minimize the potential risk; and**
(6) the final agreement, if any, reached by all involved parties.

(e) The provider shall involve the recipient and the recipient's interdisciplinary team in developing, implementing, and reviewing a negotiated risk plan.

(f) The provider shall review a negotiated risk plan with a recipient and a recipient's team at least quarterly. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 8-1-9; filed Apr 8, 2004, 3:15 p.m.: 27 IR 2493)*

460 IAC 8-1-10 Recipient records
Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-13; IC 12-15

Sec. 10. (a) An individual recipient record shall be developed and kept current and available on the premises for each recipient receiving assisted living Medicaid waiver services. In addition to the requirements of 410 IAC 16.2-5-8.1, a recipient's record shall include the following:
(1) Plan of care.
(2) Negotiated risk agreement, if any. and
(3) A written report of all significant incidents relating to the health or safety of a recipient including:
(A) how and when the incident occurred;
(B) who was involved;
(C) what action was taken by provider staff; and
(D) the outcome to the recipient.

(b) Recipient records shall be readily available to all of the following:
(1) Caregivers.
(2) Representatives of the office of Medicaid policy and planning.
(3) Division.
(4) Recipients.
(5) Recipient's authorized representatives.
(6) A recipient's case manager.
(7) Interdisciplinary team members.
(8) The ombudsman, as provided for by IC 12-10-13. and
(9) Other legally authorized persons.

(c) Records shall be kept for the time period required by 410 IAC 16.2-5-8.1 or a minimum of three (3) years, whichever is longer.

(d) If a recipient is transferred, discharged or the provider otherwise ceases to provide services, the

recipient's records shall be transferred with the recipient pursuant to 410 IAC 16.2-5-8.1. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 8-1-10; filed Apr 8, 2004, 3:15 p.m.: 27 IR 2494)*

460 IAC 8-1-11 Administration

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-10-3-9; IC 12-10-13; IC 12-15

Sec. 11. The provider shall do the following:
(1) Comply with all requirements of this article.
(2) Ensure all provider staff are knowledgeable about applicable recipient rights.
(3) Not require a recipient to sign any admission contract or agreement that purports to waive any rights of the recipient.
(4) Develop and implement a complaint procedure and process which is responsive to recipient's complaints to assist in resolving agreement disputes between recipients and the provider.
(5) Adopt procedures for securing and recording complaints and endorsements filed by:
(A) recipients;
(B) recipients' designated representatives; and
(C) recipients' family members.
(6) Post in a place and manner clearly visible to recipients and visitors the Indiana state department of health, state and local ombudsman toll-free complaint telephone numbers and telephone numbers for contacting a case manager through the local area agency on aging.
(7) Comply with all federal and state statutory and regulatory requirements regarding nondiscrimination in all aspects of the provider's operation.
(8) Encourage recipients and the recipient council, if there is one, to provide input to the facility about recipients' preferences for food choices, taking into account the cultural and religious needs of recipients.
(9) Ensure all instances of:
(A) suspected abuse;
(B) neglect;
(C) exploitation; or
(D) abandonment;
are reported to the adult protective services program, as required in IC 12-10-3-9 and 460 IAC 1-2-10, and to the local law enforcement agency.
(10) Not have any sexual contact with any recipient and shall ensure that provider staff and students not have sexual contact with any recipient.
(11) Permit the office of Medicaid policy and planning, the division, the ombudsman, and other state representatives to enter the facility without prior notification in order to monitor the provider's compliance with this article and to conduct complaint investigations, including, but not limited to:
(A) observing and interviewing recipients; and
(B) accessing recipient records.
(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 8-1-11; filed Apr 8, 2004, 3:15 p.m.: 27 IR 2494)

460 IAC 8-1-12 Payment for room and board

Authority: IC 12-8-8-4; IC 12-9-2-3
Affected: IC 12-15

Sec. 12. Each recipient is responsible for payment of the room and board services. The provider shall charge recipients room and board rates that are no higher than the SSI rate current at the time room and board services are provided, less the amount of the personal needs allowance for room and board for Medicaid eligible individuals. *(Division of Disability, Aging, and Rehabilitative Services; 460 IAC 8-1-12; filed Apr 8, 2004, 3:15 p.m.: 27 IR 2495)*

LSA Document #03-99(F)
Notice of Intent Published: 26 IR 2650

Proposed Rule Published: July 1, 2003; 26 IR 3392
Hearing Held: July 22, 2003
Approved by Attorney General: March 26, 2004
Approved by Governor: April 6, 2004
Filed with Secretary of State: April 8, 2004, 3:15 p.m.
Incorporated Documents Filed with Secretary of State: None

Indiana Family and Social Services Administration
Division of Aging
Approval Request For
Agency Providers of Assisted Living

The Indiana Family and Social Services Administration Medicaid Waiver Program is responsible for approval of providers for Assisted Living Services under Medicaid Home and Community–Based Services administered by the Division of Aging.

The attached Service Definition, Medicaid Waiver Standards and Guidelines, Level of Assessment/Evaluation, and the Indiana Assisted Living Service Survey Tool are used in this process. To apply for approval, please complete the enclosed survey tool. Return the tool and all documentation requested to:

Linda Wolcott, Waiver Operations
MS 21 Division of Aging
402 W. Washington Street, Room W454
P.O. Box 7083
Indianapolis, IN 46207-7083

When your facility is fully operational and is in compliance with all of the requirements in this survey, an on-site inspection will be scheduled to survey the assisted living services facility, meal preparation area (if applicable), and the facility's records: personnel and participants.

Any approval granted by FSSA upon review of such application and inspection shall be for the purpose of enrollment in one or more of the home and community-based services programs administered by the Division of Aging. It shall be limited to the specific services for which approval is sought, and shall be subject to the provider's execution of a Provider Agreement with the Office of Medicaid Policy and Planning (for Medicaid waivers) or a contract with the appropriate Area Agency on Aging (for other funding programs). The facility will abide by all terms and conditions of such Provider Agreement and/or contract.

Provider Name:_____

Address:_____City: _____Zip:_____

Contact Person:_____Telephone:_____

Definition of Assisted Living Services

460 IAC 8-1-2(6) (A),(B),(C),(D),(E),(F),(G)

Assisted Living waiver services means the array of services provided to a recipient residing in a facility, including all of the following:

Personal care services
Homemaker services
Chore services
Attendant care services
Companion services
Medication oversight (to the extent permitted under state law)
Therapeutic, social and recreational programming

This service also includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.

Assisted Living Service Requirement	Met	Not Met	Planned Date of Compliance	Verified Compliance	Comments/Notes
I. Unit Size 460IAC 8-1-5					
A. Does the entry door to the unit have a working lock?					
B. How many rooms					
C. Does the private bathroom contain a sink, toilet, Shower/bath?					
D. Is the bathroom wheelchair accessible (req)? (If not, is there a unit for a resident in need of wheelchair accessibility)?					
E. Is the unit at least 220 square feet including closet space but excluding the bathroom?					
F. Is there a working thermostat in the unit that is accessible to the client?					
II. Kitchenette					
A. Is there a working refrigerator?					
B. Is there a food preparation area big enough to prepare a light snack or drink?					
C. Is there a microwave?					
D. Is there access to a stove/oven for hot food preparation in a common area?					
III. Service Plan 460 IAC 8-1-7					
A. Does the Assisted Living facility have a service plan form that can be used for all residents?					
B. Does the Service Plan include the resident's					
1. Assessed health care needs?					
2. Social needs and preferences?					
3. Frequency of service and level of assistance?					
4. Limited nursing and medication services, if applicable?					

5. A place for the recipient's signature					
6. A place for the provider's signature					
7. A place for the licensed nurse's signature?					
8. A place for the case manager's signature?					
9. Does the Service Plan include the date of approval?					
IV. Cleanliness					
Is the unit free of dust, dirt, insects and rodents?					
V. Occupancy 460 IAC 8-1-5					
A. Does the Assisted Living Provider agree to grant a single occupied unit to the resident unless the resident requests and chooses to live in a dual occupied unit and the resident and the other occupant consent in writing, to the agreement?					
B. Does the Assisted Living facility have the appropriate rights and Appeal notice document for residents that are being discharged?					

Note: If the resident's Doctor or mental health professional certifies in writing that the recipient requires a single occupied unit because of specific physical, health, or mental impairment as to be danger to self or other occupants, the Assisted Living provider shall grant a single occupied unit to the resident. If no single unit is available, the Assisted Living facility will take the appropriate steps to notify the resident, the resident's family and the resident's case manager.

Inspection Documentation by FSSA Inspector or FSSA Designee

Provider Name:_____ Assessor Name: _____ Date _____

Administrator Title:_____ Assessor Name: _____ Date _____

Administrator Signature:_____ On Site Comments: _____

Date:_____ _____

_____

_____

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Division of Aging
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

E. Mitchell Roob, Jr, Secretary

TO: Housing With Services Establishment Administrators:

FROM: Michelle Stein-Ordonez, Residential Care Assistant Program Consultant
Division of Aging

RE: Disclosure Form

As stated in Indiana Code 12-10-15, effective September 1, 1999, any housing with services establishment must complete a "*Disclosure for Housing with Services Establishments*" form. This includes any freestanding facilities and/or part of a campus or complex (Independent living, nursing facility, apartment complex, hospital and/or continuing care facility.

If a disclosure form is not submitted for meeting this definition "…the business cannot: (1) enter into or extend the term of the contract with an individual to reside in a housing with services establishment or (2) use the term "Assisted Living" to describe the housing with services establishment's services and operations to the public…"

In addition to the initial filing of the disclosure forms it is required that annual updates be submitted. The updates should be submitted according to IC 12-10-15-10…Sec 10… *each year after the initial year in which an operator has filed a disclosure document under section 7 of this chapter, the operator shall file with the director within four (4) months after the end of the operator's fiscal year an annual disclosure document.*

This Form can be accessed on the FSSA website. The web address is *http://www.in.gov/fssa*.

If you have any questions regarding this law and/or completion of disclosure form, please contact Michelle Stein-Ordonez at (317)233-1956.

Attachments

10/18/2006

DISCLOSURE FOR HOUSING WITH SERVICES ESTABLISHMENTS

State Form 49028 (R / 9-05) / BAIS 0001

Date received stamp

The Disclosure for Housing with Services Establishments form is to be submitted to comply with IC 12-10-15. All sections, except Section 8, Optional Information, shall be fully completed. Section 8 is optional and provides information that you may wish to answer for potential residents who may use this form when looking for services.

A copy of the contract to be executed between the Housing with Services Establishment and the resident is the ONLY attachment that will be accepted in addition to the disclosure form. Therefore, it is important to concisely answer the questions on the form.

Indicate whether this is an original, update, or a renewal and enter date:

☐ Original Year _________ ☐ Update Year _________ ☐ Renewal Year _________

SECTION 1 - ESTABLISHMENT INFORMATION

Name of facility

On site manager's name

Address line 1

Address line 2

City	County	ZIP code
Telephone number ( )	Fax number ( )	E-Mail address

Capacity (*number of apartments*)

Is the facility licensed as a residential care facility by the Indiana State Department of Health? ☐ Yes ☐ No — If Yes, license number

Does the facility participate in the Residential Care Assistance Program (RBA/ARCH)? ☐ Yes ☐ No — If Yes, enter the 4 digit ID

Is the facility an Assisted Living Medicaid Waiver provider? ☐ Yes ☐ No

Is your facility structure (*select one*):

☐ freestanding?

☐ part of a campus or complex? (*select all that apply*)

- ☐ part of an independent apartment complex?
- ☐ part of a nursing facility?
- ☐ part of an independent living building?
- ☐ part of a hospital?
- ☐ part of a continuing care facility?
- ☐ other: _____

SECTION 2 - OWNERSHIP / TYPE OF BUSINESS INFORMATION

Name of owner/company

DBA

Address line 1

Address line 2

City	State	ZIP code
Telephone number ( )	Fax number ( )	E-Mail address

Name of managing agent (*if not owner*)

Address line 1

Address line 2

City	State	ZIP code
Telephone number ( )	Fax number ( )	E-Mail address

Type of business (*select one*):

☐ For Profit ☐ Not For Profit ☐ Government ☐ Other (*please indicate*)

Business ownership (*select one*):

☐ Sole Owner ☐ Partnership ☐ Corporation ☐ Other (*please indicate*)

Month of the year that begins your fiscal (*accounting*) year?

SECTION 3 - CORPORATE OFFICERS

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

SECTION 4 - MEMBERS OF GOVERNING BODY/ CORPORATE DIRECTORS

Name

Title | Telephone number: ( )

Address line 1

City | State: | ZIP code:

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

SECTION 4 - MEMBERS OF GOVERNING BODY/ CORPORATE DIRECTORS (*continued*)

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

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City | State | ZIP code

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

Name

Title | Telephone number ( )

Address line 1

City | State | ZIP code

SECTION 5 - BASE RATE

Normal length of lease (*contract*):

☐ 1 month ☐ 3 months ☐ 6 months ☐ 1 year

☐ Other:

MONTHLY Per Person Base Rate Ranges for all that apply:

(Note: If you convert a daily rate to a monthly rate please multiply your daily rate by 365 and then divide by 12.)

			Semi-Private Occupancy:	Kitchenette:
Studio	From: $ _____	To: $ _____	☐ Yes ☐ No	☐ Yes ☐ No ☐ Optional
One Bedroom	From: $ _____	To: $ _____	☐ Yes ☐ No	☐ Yes ☐ No ☐ Optional
Two Bedroom	From: $ _____	To: $ _____	☐ Yes ☐ No	☐ Yes ☐ No ☐ Optional

☐ Additional fees may be required (*examples - admission fee, deposit fee, buy in fee, etc.*)

☐ Additional: _____

SECTION 6 - CONTRACT INFORMATION

What is the criteria and process used to determine who may continue to reside in your facility?

SECTION 6 - CONTRACT INFORMATION (*continued*)

Can the contract be modifed or terminated by the facility? ☐ Yes ☐ No If Yes, please explain under what conditions and the referral process.

Can the contract be modifed or terminated by the resident? ☐ Yes ☐ No If Yes, please explain under what conditions and the referral process.

Outline the steps that should be taken by the resident to register a complaint and the process for resolving the complaints.

SECTION 7 - SERVICES INCLUDED IN THE BASE RATE AND / OR AVAILABLE FOR AN ADDITIONAL FEE (*check all that apply*)

MEALS: Extra meal fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Breakfast:	☐ Included	☐ Not Included	☐ Extra Fee, From: $_____	To: $_____
Lunch:	☐ Included	☐ Not Included	☐ Extra Fee, From: $_____	To: $_____
Dinner:	☐ Included	☐ Not Included	☐ Extra Fee, From: $_____	To: $_____
Snacks:	☐ Included	☐ Not Included	☐ Extra Fee, From: $_____	To: $_____

☐ Comments:

HOUSEKEEPING: Extra housekeeping fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

☐ Comments:

LAUNDRY: Extra laundry fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Bed/Bath Linens:	☐ Included	☐ Not Included	☐ Extra Fee, From: $_____	To: $_____
Personal:	☐ Included	☐ Not Included	☐ Extra Fee, From: $_____	To: $_____

☐ Comments:

PERSONAL ASSISTANCE: Extra personal assistance fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Dressing:	☐ Included	☐ Not Included	☐ Extra Fee, From: $_____	To: $_____
Toileting:	☐ Included	☐ Not Included	☐ Extra Fee, From: $_____	To: $_____
Transferring:	☐ Included	☐ Not Included	☐ Extra Fee, From: $_____	To: $_____
Mobility:	☐ Included	☐ Not Included	☐ Extra Fee, From: $_____	To: $_____
Bathing:	☐ Included	☐ Not Included	☐ Extra Fee, From: $_____	To: $_____
Eating:	☐ Included	☐ Not Included	☐ Extra Fee, From: $_____	To: $_____

☐ Comments:

SECTION 7 - SERVICES INCLUDED IN THE BASE RATE AND / OR AVAILABLE FOR AN ADDITIONAL FEE (*con't.*) (*check all that apply*)

TRANSPORTATION: Extra transportation fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Facility Scheduled: ☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

Unscheduled: ☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

☐ Comments:

UTILITIES: Extra utilities fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Heating: ☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

Air Conditioning: ☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

Electricity: ☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

Water / Sewage: ☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

Local Phone: ☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

Cable TV: ☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

☐ Comments:

Services not listed on this form that are either included or available for an additional fee:

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $_____ To: $_____

Other Wellness / Health Related Services: ☐ Yes ☐ No If Yes, explain below:

SECTION 8 - OPTIONAL INFORMATION

Do you offer wheelchair accessible units and / or common areas (*check all that apply*)?
☐ Units / Apartments ☐ Common Areas

Does each apartment have fire sprinklers? ☐ Yes ☐ No

Are pets allowed? ☐ Yes ☐ No If Yes, please describe any additional fees or special conditions below:

Do you have a nursing home / health care center at the same location? ☐ Yes ☐ No

Are rehabilitation services available on site? ☐ Yes ☐ No If Yes, please identify:

SECTION 9 - INDIVIDUAL SUBMITTING THE DISCLOSURE / MAILING INSTRUCTIONS		
Name of individual completing the form	Title	
Company / Affiliation		
Address (*number and street*)		
City, state, ZIP code		
Telephone number ( )	Fax number ( )	E-Mail address
Verified by (*name*)	Title	
Verified by (*signature*)		Date (*month, day, year*)

Send the completed form to the following address: (***Please do not FAX***)

MS 21
Assisted Living Disclosure
Division of Aging - Michelle Stein-Ordonez
402 W. Washington Street, Room W454
P.O. Box 7083
Indianapolis, IN 46207-7083

(For questions call 317-233-1956)

DO NOT WRITE IN THIS SECTION
(*For Official Use Only*)

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Division of Aging
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

E. Mitchell Roob, Jr. Secretary

NURSING FACILITY LEVEL OF CARE WAIVER
PROVIDER INFORMATION
WEBSITES

Aging Rule, 460 IAC 1.2 (effective 10/1/2006)

http://www.in.gov/legislative/iac/iac_title?iact=460 (underscore between the second "iac" and the word "title")

Indiana OPTIONS (Division of Aging website)

www.ltcoptions.in.gov

EDS Website:

www.indianamedicaid.com

Waiver Provider Manual:

www.indianamedicaid.com/ihcp/publications/manuals.html (will be added to the Publications tab at the EDS website in the near future. A printed copy can be ordered from BDDSHelp@fssa.in.gov

Consumer Guide to Indiana Medicaid Waiver Home and Community Based Services Waiver Programs:

http://www.in.gov/gpcpd/publications#4

Questions or further information? Call the Division of Aging 317-232-7122

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Division of Aging
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

E. Mitchell Roob, Jr. Secretary

FSSA DIVISION OF AGING

Policy Statement: 06-001 Revision
Date of Notice Issued: 04-21-2006

Issued to: Nursing Facility Level of Care (NF LOC) Medicaid Waiver Providers of Home and Community Based Services (HCBS)
Area Agencies on Aging (AAA)
Case Managers

Authored by: Stephen A. Smith, Director, FSSA Division of Aging

Policy Topic: Requirement of NF LOC Medicaid Waiver Providers to be CHOICE Providers

Impacts the following Waivers: All NF LOC Medicaid Waivers

Effective Date: 07-01-2006

Description of Policy Change, Update or Clarification:

On 12/06/2004, all HCBS Providers were given notification that in order for the provider to provide and be paid for HCBS through CHOICE, they would also be required to enroll as a Medicaid Waiver Provider. The deadline for that action was 01/01/2005.

As of 07/01/2006, the rates for both CHOICE services and NF LOC Medicaid Waiver services will undergo significant changes. In order to ensure that consumers of both programs will served, providers of HCBS must be accessible to both groups of recipients.

NF LOC Medicaid Waiver Providers who are not currently enrolled as CHOICE HCBS Providers are now required to do so. To do this, NF LOC Medicaid Waiver Providers must contact the local AAA's that cover the counties in which they provide services under the Waiver, and make application to become a CHOICE Provider in those same counties only for those same services, that they provide through the Medicaid Waiver. This action should be completed by 05/15/2006 in order that they may be available as providers to those on CHOICE by 07/01/2006. The following exceptions will apply, in that CHOICE Providers will not be providing the following community residential and case management services:

- Assisted Living
- Adult Foster Care
- Case Management

MEDICAID WAIVER PROVIDER
Application for Certification
For Home and Community Based Service (HCBS) Provision through the following Nursing Facility Level of Care Waiver(s)

Part 1. **Demographic Information**
Check all that apply

☐ Aged and Disabled (A&D) ☐ Traumatic Brain Injury (TBI)

_____ Check one: ☐ New Application ☐ Additional Services
Date of Application

_____
Legal Name (of person or agency)

_____
DBA (Doing Business As) if applicable

_____
Street Address (If additional service locations, please supply all information on this page for each location.)

_____ _____ _____
City State Zip Code

(___)_____ (___) _____ _____
Phone Fax E-Mail Address

_____
CEO/Administrator

_____ _____
Contact Person Title

Type of Provider Entity (Check only one):

☐ Individual _____ _____
Social Security Number (SSN) Medicaid Number

☐ Agency/Corporation _____
Federal ID Number

If Agency, specify type:

☐ Adult Day Services
☐ Adult Foster Care Home
☐ Assisted Living Facility
☐ Division of Disability and Rehabilitative Services (DDRS) Approved Agency
☐ Contractor/Construction
☐ Home/Community Service Agency (unlicensed)
☐ Home Health Agency (licensed)
☐ Retail Vendor
☐ Other (specify):_____

Part 2. MINIMUM QUALIFICATIONS FOR SERVICE PROVIDERS

All service providers (agency or individual) for the Nursing Facility Level of Care Medicaid waivers must be certified by the FSSA or its designee. This certification includes but is not limited to the completion and approval of the Waiver Application. All providers must abide by all of the provisions listed in their state licenses (if applicable), the Medicaid Waiver Provider Agreement and all other specified provisions as required by FSSA. A provider must have a valid signed Notice of Action (NOA) that specifies the service, the amount of units, and the effective date of the services, prior to providing services. The provider cannot at any time require the client to sign an agreement to pay any additional amount of money for services that they have agreed to provide under the waiver.

General Agency Requirements

a. Must comply with any applicable federal, state, county, municipal regulations that govern the operations of the agency; and all FSSA laws, rules, policies; and any applicable licensure or certification requirements
b. Must prove that appropriate and comprehensive insurance is in force
c. Must provide proof that any individual employed by the agency meets all standards and requirements for the specific services of a waiver that the individual will be providing
d. Must provide required training for any individual providing services for the waiver
e. Must provide copies of all applicable licenses
f. All agencies not licensed by the Indiana State Department of Health must obtain and submit a report (that is within the last 90 days) from the Nurse Aide Registry of the Indiana State Department of Health verifying that each employee or agent involved in the direct provision of services has not had a finding entered into the registry
g. Must show proof that all RNs and LPNs on staff have had records checked through the Indiana Health Professions Bureau
h. All agencies not licensed by the Indiana State Department of Health must obtain and submit a limited criminal history (that is within the last 90 days) from each employee involved in the direct management, administration, or provision of services from: The Indiana State Police Central Repository at 100 N. Senate Ave., Room N302, Indianapolis, IN 46204, 317-233-5424; and the county or counties of residence in the last 3 years

General Individual Requirements

a. Must be at least 18 years of age
b. Must demonstrate an ability to read and write adequately to complete required activities and meet service requirements
c. Must demonstrate the ability to understand, read and write adequately to provide the services according to the plan of care for the client
d. Must possess interpersonal skills necessary to work productively and cooperatively with clients of the waiver services and other service providers
e. Must be in adequate physical health and free from physical limitations which would interfere with the ability to perform the tasks required
f. Must be willing and able to accept on-going training as required or necessary
g. Must submit proof that appropriate liability insurance is in force
h. Must submit verification of freedom from communicable diseases as verified by physician by having a negative TB test or negative chest x-ray that has been completed within the last year
i. Must submit verification of all licenses, certifications, trainings, experiences, or degrees required by a specific service or waiver
j. Must show proof, if an RN or LPN, that record has been checked through the Indiana Health Professions Bureau
k. Must obtain and submit a report (that is within the last 90 days) from the Nurse Aide Registry of the Indiana State Department of Health verifying that there is not a finding entered into the registry if involved in the direct provision of services
l. Must obtain and submit a limited criminal history (that is within the last 90 days) from: The Indiana State Police Central Repository at 100 N. Senate Ave., Room N302, Indianapolis, IN 46204, 317-233-5424; and the county or counties of residence in the last 3 years if involved in the direct management, administration, or provision of services

Part 3. Specific Certification Requirements

For Home/Community Service Agencies that provide any or all of the following services:

Attendant Care, Homemaker, Respite Attendant Care, Respite Homemaker Services, Transportation

In addition to the completion of the Provider Application, the agency must comply with the following:

Agency Assurances

- Must be a recognized legal entity authorized to do business in the State of Indiana
- Must submit proof of Articles of Incorporation, Certificate of Incorporation, Organization, or Articles of Authority from the Secretary of State of Indiana
- Must submit proof of comprehensive insurance coverage
- Comply with all relevant federal, state, local, or municipal laws and regulations that govern the operation of the legal entity and the program
- Have a written drug free workplace policy
- Have a staff training plan
- Have back up staffing plan in place to ensure client coverage, and procedures in place to notify clients of any schedule changes
- Perform Client Satisfaction/Evaluation surveys annually
- Must submit list of all employees' names and job titles

Personnel Requirements

- Limited criminal history check from the Indiana State Police Central Repository at 100 N. Senate Ave., Room N302, Indianapolis, IN 46204, 317-233-5424; and the county or counties of residence of last 3 years for any individual providing direct management, administration, or provision of services
- Report (within the last 90 days) from the State Nurse Aide Registry of the Indiana State Department of Health verifying no findings are entered into the registry for each employee or agent involved in the direct provision of services
- Free from communicable diseases as verified by physician by having a negative TB test or negative chest x-ray that has been completed within the last year
- Current CPR certification (for employees providing attendant care /or respite attendant care services)
- Verification of Basic First Aid training (for employees providing attendant care and/or any respite services)
- Verification of training and/or experience as an attendant and/or homemaker

Part 4. WAIVER SERVICES/CERTIFICATION REQUIREMENTS

Under each applicable waiver, check all services for which you are applying for certification at this time. Please note that not all services are available on all waivers or for all types of providers.

Service Category	A&D Aged and Disabled	TBI Traumatic Brain Injury	Certification Requirements (in addition to the general requirements previously listed)
Adult Day Service (company) (A&D, TBI)	Level 1 ___ Level 2 ___ Level 3 ___	Level 1 ___ Level 2 ___ Level 3 ___	ADS Standards and Guidelines, application and site survey*
Adult Foster Care (individual) (A&D)	Level 1 ___ Level 2 ___ Level 3 ___ Level 4 ___ Level 5 ___		AFC Standards and Guidelines, application and site survey*
Assisted Living (facility) (A&D, AL)	Level 1 ___ Level 2 ___ Level 3 ___		AL Rule, Assessment Tool*; Residential Care License from ISDH; Housing with Services Disclosure form*
Attendant Care (individual, agencies) (A&D, TBI, MFC)			Individual: resume; current CPR; Home Community Services Agency guidelines; Community DD agency subject to BDDS approval.
Behavior Management (individual, agencies) (TBI)		Level 1 ___ Level 2 ___	Level 1: Psychologist and Health Services Provider in Psychology (HSPP) endorsement; Level 2: copy of Master's degree, copy of license (if applicable) and resume; Community DD agency subject to BDDS approval
Case Management (individual, agencies) (A&D, MFC, AL, TBI)			Individual certification is through their local Area Agency on Aging (AAA)
Congregate Care (A&D)	Level 1 ___ Level 2 ___ Level 3 ___		
Environmental Modifications (individual, agencies) (A&D, TBI, MFC)			Statement of Assurances and Compliance to ADA guidelines*; Individual: proof of insurance
Health Care Coordination (licensed home health agencies) (TBI)			copies of LPN and RN licenses; verification of Medicaid certification.
Home Delivered Meals (agencies) (A&D)			separate application*
Homemaker (individual, agencies) (A&D, TBI)			Home Community Services Agency guidelines; Community DD agency subject to BDDS approval; Individual: requires resume.
Personal Emergency Response Systems (individual, agencies) (A&D, TBI)			verification of qualified contractor (business or individual) and/or retail license
Physical Therapy (individual, agencies) (TBI)			
Occupational Therapy (individual, agencies) (TBI)			
Residential Habilitation (agencies) (TBI)			subject to BDDS approval

Service Category	A&D Aged and Disabled	TBI Traumatic Brain Injury	Certification Requirements (in addition to the general requirements previously listed)
Respite Attendant Care (individual, agencies) (A&D, TBI)			Home Community Services Agency guidelines; Community DD agency subject to BDDS approval; Individual: requires resume; first aid training; CPR
Respite Home Health Aide (licensed home health agencies) (A&D, TBI)			
Respite Homemaker (individual, agencies) (A&D, TBI)			Home Community Services Agency guideline; Community DD agency subject to BDDS approval; Individual: requires resume; first aid training
Respite LPN (licensed home health agencies) (A&D, TBI, MFC)			
Respite RN (licensed home health agencies) (A&D, TBI, MFC)			
Specialized Medical Equipment and Supplies (individual, agencies) (A&D, TBI)			verification of qualified contractor (business or individual) and/or retail license; verification as required by the Registry for Interpreters of the Deaf (TBI)
Speech/Language Hearing Therapy (individual, agencies) (TBI)			
Structured Day Program (agencies) (TBI)			subject to BDDS approval; verification of CARF certification.
Supported Employment (agencies) (TBI)			subject to BDDS approval; verification of CARF certification
Transportation (agencies) (A&D, TBI)			Community DD agency subject to BDDS approval; verification of Medicaid certification; Statement of Assurances and Compliance for Transportation*
Vehicle Modification (individual, agencies) (A&D, TBI, MFC)			verification of qualified automotive vehicle specialist.

*For additional applications and resources specified in this application, contact 317-232-7122.

Part 5. Medicaid Waiver Provider's Statement of Assurances and Compliance

Check off the assurances before signing. Signatures must be from an individual authorized to sign for the provider entity.

☐ 1. Provider assures that, if approved, the provider entity complies and will maintain compliance with all requirements as specified in this application, and all applicable state and federal statues, regulations and licensure requirements for the approved service(s).

☐ 2. Provider assures that, if approved, the provider entity will provide only those Medicaid Home and Community Based Service(s) which have been authorized in the recipient's individual Plan of Care/Cost Comparison Budget, and in accordance with the Provider Agreement. and Certification requirements.

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Submit the entire completed application, including the signed Statement of Assurances and Compliance, and all documentation for specified certification requirements.

Incomplete applications will be returned.

Mail application and all supporting documents to:

Linda Wolcott, Waiver Operations
MS 21 Division of Aging
402 West Washington Street, Room W454
P.O. Box 7083
Indianapolis, In 46207-7083
Phone (317) 234-0373
Fax (317) 232-7867

SCHEDULE A
INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION
MEDICAID HOME AND COMMUNITY-BASED SERVICES
WAIVER PROVIDER AGREEMENT

Provider agrees to provide only those Medicaid Home and Community-Based Services which meet the following criteria:

1. Services which the Provider is licensed or certified to provide (if applicable);
2. Services for which the Provider has received formal certification form the Medicaid Waiver certification;
3. Services which have been authorized by the recipient's waiver case manager or targeted case manager (as appropriate) as set out in the recipient's Plan of Care; and
4. If applicable, in accordance with any addendum to this Agreement

Provider Name: _____

Doing Business As (if legal name is different from provider name stated above). If DBA name is different from provider name, provide documentation:
_____

Home Office address: _____

Mailing address: _____

Pay To address: _____

Service Location(s) (if different from above): _____
_____

Telephone Number: _____

E-mail address: _____

Social Security # or Federal ID# (not both): _____

Check one of the following: _____Individual____ Partnership
_____Corporation _____ Not-For-Profit

List current Medicaid Provider Number, if any: _____
List current Medicaid Waiver Provider number, if known: _____
List current Medicare Provider Number, if any, **and specify type (i.e., home health agency, AAA, etc.):**
_____
Typed or Printed Name of Authorized Representative: _____

Title: _____ Date: _____

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION
MEDICAID HOME AND COMMUNITY BASED SERVICES
WAIVER PROVIDER AGREEMENT

By execution of this Agreement, the undersigned entity ('Provider") requests enrollment as a provider of services or supplies to recipients of Home and Community-Based Services authorized under the Medicaid Home and Community-Based Services Waiver Programs (hereinafter, "Medicaid Waiver"'), and as a condition of enrollment, Provider agrees:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration (IFSSA).

2. To comply with all federal and state statutes and regulations pertaining to the Medicaid Program including the Medicaid Waiver Program, as they may be amended from time to time.

3. To meet, on a continuing 'basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Medical Assistance law, State of Indiana's Medicaid Waiver program, or any rule or regulation. promulgated pursuant thereto.

4. To notify IFSSA or its agent within then (10) days of any change in the status of Provider's license, certification or permit to provide its services to the public in the State of Indiana.

5. To provide Medicaid Waiver-covered services and/or supplies for which federal financial participation is available for Medicaid Waiver recipients pursuant to all applicable federal and state statutes and regulations.

6. To safeguard information about Medicaid recipients, including at least:

    a. recipient's name, address, and social and economic circumstances;
    b. medical services provided to recipients;
    c. recipient's medical data, including diagnosis and past history of disease or disability;
    d. any information received for verifying recipient’s income eligibility and amount of medical assistance payments;
    e. any information received in connection with the identification of legally liable third party resources.

7. To release information about Medicaid recipients only to the I FSSA, its agent, or a Medicaid Wavier recipients case manager or targeted case manager and only when in connection with:

    a. Providing services for recipients; and
    b. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of Medicaid covered services.

8. To maintain a written - contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the 'legal responsibility of the provider to the agency to assure that all activities under the contract are carried out.

9. To submit claims for services rendered by the provider or employees of the provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (e.g. hospital, ICF-MR, nursing home) or a government agency with a contract that meets the requirements described in paragraph 8 of this Agreement Healthcare facilities and government agencies' may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide Medicaid-covered services rendered pursuant to this Agreement .

10. To comply, if a hospital, nursing facility, provider of home health care and personal care services, hospice, or HMO; with advance directive requirements as required by 42 'Code of Federal Regulations, parts 489, subpart I, and 417.436.

11. To abide by the Indiana Health Coverage Programs Provider Manual, as amended from time to time, the Medicaid Waiver Programs Provider Manual, as amended from time to time, as well as all provider bulletins and' notices. Any amendments to the Indiana Health Coverage Programs Provider Manual, the Medicaid Waiver Program, as well as provider bulletins and notices communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" on file with IFSSA or its fiscal agent.

12. To submit timely billing on Medicaid approved claim forms, as outlined in the Medicaid Waiver Programs Provider Manual, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

13. To be individually responsible- and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable Federal and/or State law.

14. To submit claim(s) for Medicaid Waiver reimbursement only after first exhausting all other sources of reimbursement as required by the Indiana Health Coverage Programs Provider Manual, bulletins, and banner pages.

15. To submit claim(s) for Medicaid Waiver reimbursement utilizing the appropriate claims forms and, codes as specified in the Medicaid Waiver Programs Provider Manual, bulletins, and notices.

16. To submit claims that can be documented by Provider as being strictly for:

    a. those services and/or supplies authorized by the recipients waiver case manager or targeted case manager for individuals with developmental disabilities; . .
    b. those services and/or supplies actually provided to the recipient in whose name the claim is being made; and
    c. compensation that Provider is legally entitled to receive.

17. To accept payment as payment in full the amounts determined by IFSSA or its fiscal agent in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid waiver covered services provided to Medicaid Waiver recipients. Provider agrees not to bill recipients or any member of a recipient's family, for any additional charge for Medicaid Waiver covered services, excluding and co-payment permitted by law.

18. To refund within fifteen (15) days of receipt, to IFSSA or its fiscal agent any duplicate or erroneous payment received.

19. To make repayments to IFSSA or its fiscal agent or arrange to have future payments from the Medicaid or Medicaid Waiver programs withheld, within sixty (60) days of receipt of notice from IFSSA . or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending.

20. To pay interest on overpayment in accordance with IC 12-15-13-3, IC 12-15-21-3, and IC 12-15-23-2.

21. To make full reimbursement to IFSSA or its fiscal agent of any federal disallowance incurred by IFSSA when such disallowance relates to payments previously made to Provider under the Medicaid or Medicaid Waiver programs.

22. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.

23. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Medicaid or Medicaid waiver payments made to Provider, to assure the proper administration of the Medicaid and Medicaid Waiver programs and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in' the "Provider Requirements" Section of the Waiver. Provider Manual and shall include, without being limited to, the following: *(405/AC* 1-5)

    a. Medical records as specified by Section 1902(a) (27) of Title XIX of the. Social Security Act and any amendments thereto;
    b. records of all treatments, drugs, services and/or supplies for which vendor payments have been made, or are to be made under the Title XIX Program, including the authority for and the date of administration of such treatment, drug, services and/or supplies;
    c. any records determined by IFSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program;
    d. documentation in each recipient's record that will" enable the IFSSA or its agent to verify that each charge is due and proper;
    e. financial records maintained in the standard, specified form;
    f. all other records as may be found necessary by the IFSSA or its agent in determining compliance with any Federal or State law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the IFSSA.

24. To cease any conduct that IFSSA or its representative deems to be abusive of the Medicaid or Medicaid Waiver programs.

25. To promptly correct deficiencies in Provider's operations upon request of IFSSA or its fiscal agent.

26. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:

    a. the petitioner is a person to whom the order is specifically directed;
    b. the petitioner is aggrieved or adversely affected by the order; and
    c. the petitioner is entitled to review under the law.

27. Provider must file a statement of issues within the time limits listed below, setting out in detail:
    a. the specific findings, actions, or determinations of IFSSA from which Provider is appealing;
    b. with respect to each finding, action or determination, all statutes or rules supporting Provider's contentions of error.

28. Time limits for filing an appeal and the statement of issues are as follows:

    a. The provider must file an appeal of determination that an overpayment has occurred within sixty (60) days of receipt of IFSSA's determination. The statement of issues must be filed within 60 days of receipt of IFSSA's determination.
    b. All appeals of actions not described in (a) must be filed within fifteen (15) days of receipt of IFSSA's determination. The statement of issues must be filed within. Forty-five (45) days of receipt of IFSSA's determination.

29. To cooperate with IFSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.

30. To comply with civil rights requirements as mandated by federal and state statutes and regulat10ns by ensuring that no person shall on the basis of race, color, national origin, ancestry, disability, age, sex, or religion be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination in the provision of a Medicaid or Medicaid Waiver-covered service.

31. To comply with 42 Code of Federal Regulations, part 455, .subpart B pertaining to the disclosure of information concerning the ownership and control of the provider, certain business transactions, and information concerning persons convicted of crimes. Said compliance will include, but is not limited to, giving written notice to I FSSA, the State's Medicaid. Waiver Specialist and its fiscal agent, at least sixty (60) days before making a change in any of the following: Name (legal name, DBA name, or name as registered with the Secretary of State), address (service location," pay to," "mail to,", or home office), federal tax identification number(s), or change in the provider's direct or indirect 'ownership' interest or controlling interest. Pursuant to 42 Code of Federal Regulations, part 455.104(c), IFSSA must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.

32. To furnish to IFSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in Schedule A t to this Agreement, which is incorporated here by reference, and to update this information as it may be necessary.

33. That subject to item 32, this Agreement shall be effective as of the date set out in the provider notification letter.

34. If the Provider provides direct services, to provide waiver' services solely as authorized in the recipients Plan of Care/Cost Comparison Budget prepared by the recipients case manager or targeted case manager and as the services are defined in the Medicaid Waiver Provider Manual and the appropriate waiver.

35. To provide at least 30 (thirty) days written notice to the recipient and/or recipient's legal representative, the recipient's case manager or targeted case manager, if applicable, and the State's Medicaid Waiver Specialist before terminating waiver services to a recipient

    a. If the Provider is providing direct services, prior to terminating services, the Provider shall participate in an Interdisciplinary Team meeting to coordinate the transfer of services to a new provider. The Provider agrees to continue serving the recipient until a new provider providing 'similar services is in place, unless written permission has been received from the State's Medicaid Waiver Specialist authorizing the provider to cease providing services before a new provider begin providing.

    b. If the Provider is providing case management services, the Provider shall participate in an Interdisciplinary team meeting, at which the recipient's new case manager is present. The purpose of the Interdisciplinary meeting will be to coordinate the transfer of case management services to the new case manager. The Provider agrees to continue serving the recipient until a new case manager is serving the recipient, unless written permission has been received from the' State's Medicaid Waiver Specialist authorizing the Provider to cease providing services before a new provider begins providing services.

36. To report any incidents (including suspected abuse, neglect or exploitation) to Adult Protective Services or Child Protective Services, the appropriate Area Agency on Aging and the recipient's case manager. If the waiver recipient is developmentally disabled a report shall also be made to the Bureau of Developmental Disabilities Services

37. To comply with Provider and Case Management Standards issued by the Division of Disability, Aging, and Rehabilitative Services, as applicable, and as amended from time to time. These standards are binding upon receipt unless otherwise stated. Receipt will be presumed when the standards or any amendments are mailed to the Provider's current address on file with IFSSA or its fiscal agent.

38. That this Agreement may be terminated as-follows:

    A. By IFSSA or its fiscal agent for Provider's breach of any provision of this Agreement;
    B. By IFSSA or its fiscal agent, or by Provider, upon 60 days written notice.

39. That this Agreement, upon execution, .supersedes and replaces any provider agreement previously executed by the Provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE' PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 USC 1320a-7b MAYBE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF NOT MORE THAN FIVE YEARS OR BOTH.

Provider-Authorized Signature - All Schedules
The 9Wner or an authorized officer of the business entity must complete this section

I certify, under penalty of law, that the information stated in Schedule A is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicated that the information has been falsified; I may be considered for suspension from the program and/or prosecution for Medicaid Fraud. I hereby authorize the Indiana Family and Social Services Administration to make any necessary verifications of the information provided herein, and further authorize and request each educational institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in the Indiana Medicaid Waiver Program.

Provider DBA Name_____

Tax ID _____

Officer Name _____ Title _____

Signature _____ Date _____

Telephones Number _____

Note: Failure to complete this section will result in the State returning the application for incomplete information.

Revised 1/2002

Form **W-9**
(Rev. January 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ .....

☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person ▶ Date ▶

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note. *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov/online/ss-5.pdf*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses/* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

COUNTY SURVEY

Provider Name: _____

Doing Business as (DBA): _____

Contact Person: _____

Telephone Number: _____

Please circle the number of **each** county in which you are willing to provide the service(s). The Medicaid Waiver Unit database lists waiver providers by the counties they serve; waiver case managers utilize the database to refer waiver clients to providers serving a client's county of residence.

COUNTY	COUNTY	COUNTY
1. ADAMS	32. HENDRICKS	63. PIKE
2. ALLEN	33. HENRY	64. PORTER
3. BARTHOLOMEW	34 HOWARD	65. POSEY
4. BENTON	35. HUNTINGTON	66. PULASKI
5. BLACKFORD	36. JACKSON	67. PUTNAM
6. BOONE	37. JASPER	68. RANDOLPH
7. BROWN	38. JAY	69. RIPLEY
8. CARROLL	39. JEFFERSON	70. RUSH
9. CASS	40. JENNINGS	71. SAINT JOSEPH
10. CLARK	41. JOHNSON	72. SCOTT
11. CLAY	42. KNOX	73. SHELBY
12. CLINTON	43. KOSCIUSKO	74. SPENCER
13. CRAWFORD	44. LAGRANGE	75. STARKE
14. DAVIESS	45. LAKE	76. STEUBEN
15. DEARBORN	46. LAPORTE	77. SULLIVAN
16. DECATUR	47. LAWRENCE	78. SWITZERLAND
17. DEKALB	48. MADISON	79. TIPPECANOE
18. DELAWARE	49. MARION	80. TIPTON
19. DUBOIS	50. MARSHALL	81. UNION
20. ELKHART	51. MARTIN	82. VANDERBURGH
21. FAYETTE	52. MIAMI	83. VERMILLION
22. FLOYD	53. MONROE	84. VIGO
23. FOUNTAIN	54. MONTGOMERY	85. WABASH
24. FRANKLIN	55. MORGAN	86. WARREN
25. FULTON	56. NEWTON	87. WARRICK
26. GIBSON	57. NOBLE	88. WASHINGTON
27. GRANT	58. OHIO	89. WAYNE
28. GREENE	59. ORANGE	90. WELLS
29. HAMILTON	60. OWEN	91. WHITE
30. HANCOCK	61. PARKE	92. WHITLEY
31. HARRISON	62. PERRY	

The list and map on the following pages show each Area Agency on Aging, with the counties included in each AAA's jurisdiction. The Medicaid Waiver Unit suggests that new providers contact each Area Agency in whose counties the provider will deliver waiver services, so the AAA becomes acquainted with new providers in the area. 2/05

16 Area Agencies on Aging

AREA 1
Northwest Indiana Community Action Corp.
5240 Fountain Dr.
Crown Point, IN 46307
(219) 794-1829 or (800) 826-7871
TTY: (888) 814-7597
FAX (219) 794-1860
Web Site: www.nwi-ca.com
E-Mail: golund@nwi-ca.org
Gary Olund, Executive Director
Jennifer Malone, Director of Elderly Services

AREA 2
REAL Services, Inc.
1151 S. Michigan St., P.O. Box 1835
South Bend, IN 46634-1835
(574) 233-8205 or (800) 552-2916
FAX (574) 284-2642
Web Site: www.realservicesinc.com
Becky Zaseck, President, C.E.O

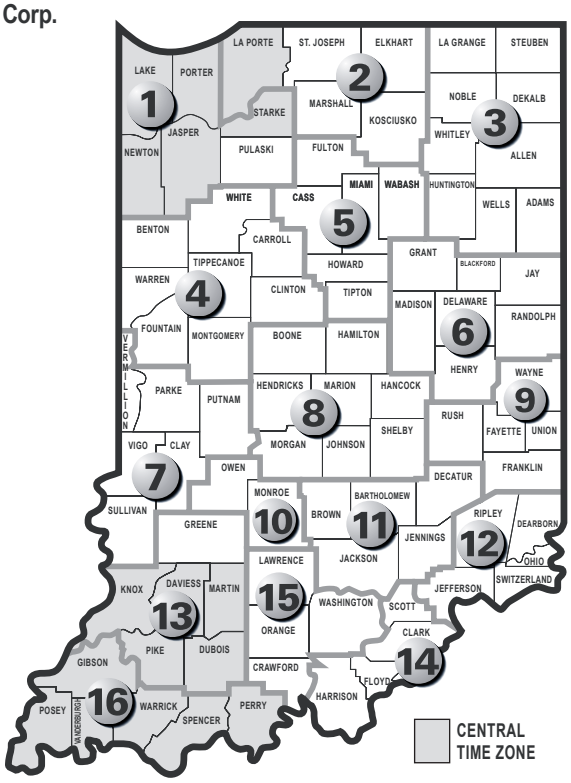
AREA 3
Aging and In-Home Services of Northeast Indiana, Inc.
2927 Lake Avenue
Fort Wayne, IN 46805-5414
(260) 745-1200 or (800) 552-3662
FAX (260) 456-1066
Web Site: www.agingihs.org
E-Mail: dmccormick@agingihs.org
Diann McCormick, President

AREA 4
Area IV Agency on Aging & Community Action Programs, Inc.
660 North 36th St., P.O. Box 4727
Lafayette, IN 47903-4727
(765) 447-7683 or (800) 382-7556
TDD (765) 447-3307; FAX (765) 447-6862
E-Mail: info@areaivagency.org
Web Site: www.areaivagency.org
Sharon Wood, Executive Director

AREA 5
Area Five Agency on Aging & Community Services, Inc.
1801 Smith Street, Suite 300
Logansport, IN 46947-1577
(574) 722-4451 or (800) 654-9421
FAX (574) 722-3447
E-Mail: areafive@areafive.com
Web Site: www.areafive.com
Michael Meagher, Executive Director

AREA 6
LifeStream Services, Inc.
1701 Pilgrim Blvd., P.O. Box 308
Yorktown, IN 47396-0308
(765) 759-1121 or (800) 589-1121
TDD (800) 589-1121; FAX (765) 759-0060
E-Mail: mail@lifestreaminc.org
Web Site: www.lifestreaminc.org
Kenneth D. Adkins, President/CEO

AREA 7
Area 7 Agency on Aging and Disabled West Central Indiana Economic Development District, Inc.
1718 Wabash Ave., P.O. Box 359
Terre Haute, IN 47808-0359
(812) 238-1561 or (800) 489-1561
TDD (800)489-1561; FAX (812) 238-1564
E-Mail: Area7AAD@netscape.net
Mervin Nolot, Executive Director



AREA 8
CICOA Aging and In-Home Solutions
4755 Kingsway Dr., Suite 200
Indianapolis, IN 46205-1560
(317) 254-5465 or (800) 489-9550
FAX (317) 254-5494; TDD (317) 254-5497
Web Site: www.cicoa.org
Duane Etienne, President, C.E.O.

AREA 9
Area 9 In-Home & Community Services Agency
520 South 9th St.
Richmond, IN 47374-6230
(765) 966-1795, (765) 973-8334 or
(800) 458-9345
FAX (765) 962-1190
E-Mail: ashepher@indiana.edu
Web Site: www.iue.indiana.edu/departments/Area 9
Tony Shepherd, Executive Director

AREA 10
Area 10 Agency on Aging
630 W. Edgewood Drive
Ellettsville, IN 47429
(812) 876-3383 or (800) 844-1010
FAX (812) 876-9922
E-Mail: area10@area10.bloomington.in.us
Web Site: www.area10.bloomington.in.us
Jewel Echelbarger, Executive Director

AREA 11
Aging & Community Services of South Central Indiana, Inc.
1531 13th Street, Suite G-900
Columbus, IN 47201-1302
(812) 372-6918 or (866) 644-6407
FAX (812) 372-7846
Web Site: www.agingandcommunityservices.org
E-Mail: dcantrell@areaxi.org
Diane Cantrell, Executive Director

AREA 12
***Life*Time Resources, Inc.**
13091 Benedict Drive
Dillsboro, IN 47018
(812) 432-5215 or (800) 742-5001
FAX (812) 432-3822
Web Site: www.lifetime-resources.org
E-Mail: contactltr@lifetime-resources.org
Sally Beckley, Executive Director

AREA 13
Generations
Vincennes University Statewide Services
1019 North 4th Street
P.O. Box 314
Vincennes, IN 47591
(812) 888-5880 or (800) 742-9002
FAX (812) 888-4566
E-Mail: generations@vinu.edu
Web Site: www.generationsnetwork.org
Anne N. Jacoby, Assistant Vice President

AREA 14
LifeSpan Resources, Inc.
426 Bank Street, Suite 100, P.O. Box 995
New Albany, IN 47151-0995
(812) 948-8330 or (888)948-8330
FAX: (812) 948-0147
E-Mail: kstormes@lsr14.org
Web Site: www.lifespanresources.org
Keith Stormes, Executive Director

AREA 15
Hoosier Uplands/Area 15 Agency on Aging and Disability Services
521 West Main Street
Mitchell, IN 47446
(812) 849-4457 or (800) 333-2451
TDD (800) 743-3333; FAX (812) 849-4467
E-Mail: area15@hoosieruplands.org
Web Site: www.hoosieruplands.org
David L. Miller, CEO
Barbara Tarr, Director of Aging and Disability Services

AREA 16
Southwestern Indiana Regional Council on Aging, Inc.
16 W. Virginia St., P.O. Box 3938
Evansville, IN 47737-3938
(812) 464-7800 or (800) 253-2188
FAX (812) 464-7843 or (812) 464-7811
E-Mail: swirca@swirca.org
Web Site: www.swirca.org
Robert J. "Steve" Patrow, Executive Director

To contact your local Area Agency toll-free, call
1-800-986-3505